The International Casemix Panel
9.00 – 10.00 AM
Room: Koos Speenhof 2

schongallatg@gmail.com 509 522 4734 Walla Walla, Washington

Topics to be addressed:

- the current health care system and the way it is financed and what role is played by Casemix Systems.
- the Major events in your country’s health care policy
- the way health care costs of the people are covered?
- the role of Casemix systems and its maintenance process to keep up with innovations
- the major challenges for the funding of health care
- the major issues with Casemix in your country?
- the actions do you recommend for the next 5 years to make the system sustainable?

The health care system is financed by taxes, premiums, deductibles and co-pays. The total amount is about $9100 per person per year or 18% of GDP. 15% are still uninsured. Inflation is still higher in the health care sector than in the general economy. General revenue outlays increase annually to cover Medicare and Medicaid. State budgets are overwhelmed by the increase in the Medicaid portion of health care program. The total outlays for health are more than $2.7 trillion per year. This amount represents about 18% of GDP in 2013.

Case mix in particular is used to calculate payments for all Medicare Hospital admissions. A surprising development over the past 30 years is that more than 90% of all hospital payments are calculated with DRG Casemix being the basic rule. The payments are actuarially adjusted for co-pays and deductibles. The Resource Based Relative Value Scale is the rate schedule by which physicians generally are paid. The RBRVS is maintained and updated by the medical assn.

The major event of the past five years has been the passing of major health reform to cover the uninsured and to improve insurance company practices – Affordable Care Act. There has been gradual implementation for individuals and employers since 2010, with the majority of changes coming after 2014. There has been terrific political tension over the expansion, and some states have refused the Medicaid dollars offered. 15% are still uninsured. Illegal immigrants make up more than 11 million of the uninsured.

There has also been a major effort to get hospitals and doctors offices to use systemic electronic health records. A series of generous awards was legislated to get compliance.

Innovation has continued and the Medical Payment Advisory Commission regularly considered new technology and makes allowances for it. Innovation does not seem to have been slowed in the past 30 years,

The challenges to funding are substantial creeping increases in Federal & State taxes, deductibles, co-pays and premiums. There is a steady trend for more general revenue to be spent on government health programs. The average co-pay is $1,145 a year. Deductibles are typically more than $1000 for Medicare and often reach $6000 for private, Medicare Advantage and Company insurance policies. A good portion of the annual federal deficit can be tied to entitlement spending.
The major challenges are to get more individuals insured, and to keep the total cost of medical care within limits. We are headed to 20% of GDP, and there seem to be nothing that stops the creep upward, at some point a limit is reached on what any society can spend on medical care. But that level is unknown. Family coverage is $17,000 a year. Individual coverage costs more than $6000 per year. In 2013 Medicare spent $12,430 per person per year for 55 million beneficiaries. Physicians have successfully overcome a major effort to rein in their payments. The legislated sustainable growth rate did not work to restrain physicians.

Major issues are escalating costs, maintenance & coverage of rural area hospitals & people, and insuring the uninsured at a reasonable cost. Medicare and Medicaid take up $1.3 trillion budget resources per year, and must be reined in somehow in the next decades. There is not really effective competition between insurers for coverage policies.

The medical schools, physicians, the elderly and the poor are very important elements in the political firmament. Politicians have a hard time handling their demands. No one seems to be able to stand up to the demands of the various groups. There should be a major expansion of medical school, and a focus on the education of primary care physicians.

Actions I recommend: 1. Keep up the effort to expand insurance. 2. Continue to ratchet down payments via casemix & physician payment regimen. 3. Continue to encourage the development of system wide transportable electronic health records. 4. The controversial Independent payment advisory board should be appointed and staffed to examine, control & restrain current medical practices. 5. Medicare should be encouraged and allowed to negotiate drug purchase prices.

The public must be educated to expect higher out of pocket and higher uncovered health care costs. Somehow the fiscal problem of entitlements needs to be brought forward and addressed. It is impossible to spend $250,000 a person for the aged & disabled, and only collect $150,000 in taxes, premiums, co-pays and deductibles. The system as currently operating is not sustainable.

Complex American Medicare Casemix Payment System – Known as DRG Payments.

Three non partisan commissions MEDPac, ProPAC, PPRC have generated 30 – 40 thousand pages of analysis. All public domain & some available on line.
State of Maryland has a staff of 25 commission and an “all payer” DRG System Casemix is a hospital product line system – industrial engineering technique

Other major events in the American health care policy:
Affordable Care Act – 7% more of the population covered @trillion dollar 10 yr cost
ICD 10 Coding adopted, mandated in FY 2015.six years to adopt ICD 10.

55 million adults covered. 46 million over 65 & 9 million disabled. 98% Over 65
$12,430/$680 billion/year Medicare&$600 billion/50 Medicaid [states]
Also consider RBRVS for physicians & RUGS For Nursing Homes
CPT costs of $100 million/year to AMA Medicare part A & B & D
We will not discuss the Relative Value Scale or the Resource Utilization Groups
Sustainable growth rate overcome and replaced. [SGR] Failed effort

Stable system with a regular yearly pattern. 30+ years of use.
Basic [[Casemix weight] [casemix adjusters] [base amount] = hospital payment
Rebasing and reweighing every year. 3M publishes a grouper each year.
System – CMS, Regional Offices, Three big Fiscal Intermediaries with appeal system.
DRG’s installed over a period of four years 1982 – 1986 Fiscal years. Jiggle
RBRVS 1992-95 sophisticated scientific rate schedule for physicians.
Every year – manipulation and adjustment at the edges of the programs.
Congress - Ways & Means, Senate Finance, Energy & Commerce
Ratchet down reimbursement payments each year. 95% cost
Center for Medicare & Medicaid Services – Federal Agency in HHS
Other health sector players – five insurers – fiscal intermediaries - self

Pattern - Administrative Procedure Act [1946]
Feb 100 single spaced proposal of changes is published in Fed Register.
90 day period of public comment. Thousands of pages of comment
Final Rule and reaction comments are published
1 October is time to apply the new rule. New Rates apply.

Adjustments over the years - urban/rural wage differential index
Effects on reimbursement - e.g. severity of illness/disease staging.
Number of DRG's & other refinements 468 to 600+ DRGS now.
Cost & Day outliers not mentioned very often in recent years.
Medical Education payments from Medicare. [unusual]
Indirect Medical Education Adjustment Payments
Disproportionate share payments – recently reduced because ACA

Exceptions to Casemix payments. Hospitals can document & file special circumstances
Children’s & Units; Cancer & Units; Rehab & Psych Hospitals & units
Depreciation and Capital costs – pass through [Inability to fold in]
Periodic Interim Payments to hospitals to smooth out the payments over the year.
PSRO/PRO to monitor performance and review discharges to prevent premature disch.

Exceptions to Casemix in US health care – Miscellaneous hospitals & systems
Veterans Administration Hospitals – capitation payment & appropriated
Department of Defense Hospitals – global budget - Operations & Maintenance
Indian Health Service Hospitals – global budget appropriated.

Migration to the universe of health insurers with modification of the base amount for pay.
Casemix dominant for all payers though only mandated for Medicare Program

Problems: Health care inflation. 8.5% gdp in ’85, 17% gdp in ’14 $9000/person/year
Hospital staff considers the DRG day schedule as a limit not an average LOS.
Nursing manpower shortage – $35/hr/Nursing Diagnosis off radar screen.
Hospital Closures from 7000+ to 5000+ one quarter rural
ICD 10 introduction in FY 15 – major software challenges.
Integration of capital costs into basic system. Has not been achieved.
Coding creep – history of creep through 30 year history of program
Shift of care to Same Day Surgi Centers from Hospital
Ambulatory care increases: Creation of Ambulatory Visit Groups
Dual Eligible’s – Medicare & Medicaid: very high cost per participant
Big City large hospitals and care of poor & uninsured.
Rural hospital where reimbursement not sufficient to maintain hospital
SCP, RRC, CAH etc special arrangements to maintain. REACH prop.

Exceptions awards system at CMS
Provider Reimbursement Review Board. 5 member board at CMS
Severity of Illness/Disease Staging utilization and acceptance. Recently legislated and adopted

Real case – same day surgery, emergency room visit, four day hospital stay. $53,500 bill
DRG 370 pays $10,400 for four day stay. $2600/day. Billed $7250 day.
RBRVS & Bundled payments of $3000 for same day surgery at hospital
Emergency Room costs subsumed into DRG 370 only physician charges paid
System of co pays deductibles & secondary payers. e.g. Part A & B
Medicaid as secondary payer/10+ % – high cost to CMS
St Mary’s Providence Health System $4 billion a year. 46,000 employees. 7.8% profit
St Mary’s Providence Walla Walla 79 beds, one of two general hospitals.
St Mary’s Medical Group for Physicians – large group practice
Physician contracts private documents, and not available
Urologist Salary and profit sharing $300,000 - $500,000 per year.
Anesthesiologist similar arrangement
Hospital based and clinic based practices paid differently. Part B
Financial office in Oregon for entire St Mary’s System

Appendix A

Description Events:
Case 1 Prostate clearing
Case 2 Half hip replacement

Givens & Assumptions

Case 1 [Medicare] – Payment on the Basis of Law and Regulations 12,430 yr
Medicare Secondary Payer insurance e.g. Mutual of Omaha
Blue Cross, etc.

Case 1A [Medicare Advantage] – Payment on basis of Law & Federal Regulations
Varied Deductibles and Co-pays

Case 2 [Medicare & Medicaid] – same as above but add State Regulations
Medicaid serves as the secondary payer.

Case 3 [Medicaid Only] – Payment by Law, Federal Regulations, State Law & Regulations – Full payment. No obligation by beneficiary. 3,450 per year

Case 4 [Company Provided Insurance] – contractual arrangement with Corporation
Generally Deductibles and Co-pays.
Multiple types and levels of insurance
“Cadillac Plans” – very generous insurance coverage

Case 4A [Company Self Insurance Program] - group contractual arrangement
Insurer as administrator of plan
Generally Deductibles and Co-pays
Multiple policies in many companies.

Case 5 [Individual Insurance Contract] – contractual arrangement
e.g Federal Employees Health Benefit Plan = $12,000 F/$4500 I

Case 6 [Affordable Care Act Insurance Contract] - individual contractual arrangement
Substantial Deductibles and Co-Pays
Deductibles $3000 to 60000 depending on policy
CoPays 20, 30, 40% depending on purchase of policy

Case 7 [Uninsured] – no contract or arrangement – Chargemaster Adjusted

Case 8 [Self Pay] – no contract or arrangement – Chargemaster Adjusted

Tax sheltered savings account that accrues
Catastrophic coverage contract purchases
Chargemaster adjusted billing